Medical Director Update – Hampshire/IOW/Thames Valley Q3 2018-19

Tackling health inequalities

We all have a desire to improve life expectancy and to reduce health inequalities. Cardiovascular disease remains our biggest killer and a major cause of disability. We have been developing our plans to make a major dent on its impact. The evidence base tells us that detecting and treating high blood pressure, atrial fibrillation and cholesterol along with tackling smoking will lead, in a relatively short period of time, to a major reduction in mortality. Steve Powis, National Medical Director, highlighted the opportunities for us to move to Canadian levels of hypertension detection and control at the Annual Medical Director's Forum. Alongside this we have been producing a toolkit of actions which make a difference when leading clinical change at the 2 to 5 million population level.

2017/18 QoF results are now available on Fingertips. It's pleasing to see that Slough were the second best CCG in the country for controlling the blood pressure (140/80) of people with diabetes.

Promoting equality and diversity

It is important for us to promote equality and diversity and with the workforce challenges we face, it is important that every person who wants to help the NHS feels that there is genuine equality of opportunity and no glass ceiling. With this in mind three of our medical leaders, Dr Sarah Schofield, Dr Lalitha Iyer and Dr Kiren Collison are working together to look at how to promote diversity in medical leadership.

Mental health in an STP and improving quality in primary care

I recently attended a national meeting at which there were two really interesting presentations about how people were looking to improve primary care quality. Dr Maurice Conlon described how his practice had developed governance processes, in-house reviews and produced an annual report. The slides can be found here. Dr Sanjeev Kapur gave a presentation entitled 'Raising the bar: How working at scale might be good for governance' about how his and a group of other practices had come together to work at scale, and how this was beginning to show improvements in quality. His slides are available here. Another outstanding presentation that day was from Dr Rajesh Nadkarni (Medical Director of Northumberland Tyne and Weir NHS Foundation Trust) who outlined how

mental health was a major part of their STP and how their skills were being used to treat people presenting with physical symptoms.

Conferences

We have held two large scale conferences recently; one on cancer in the Thames Valley and one on mental health in Wessex. The Leadership Academy ran an excellent annual conference in Winchester. I do hope that next year even more clinicians take the opportunity to attend this excellent event. Whilst very resource intensive to organise, these conferences accelerate the dissemination of best practice, and allow large numbers of people to come together.

Obesity

Colleagues will recall that Professor Susan Jebb gave two excellent presentations on obesity at our 2017 Medical Directorate conferences in January and July of that year. The content of her presentations (which can be found here and here), focused on the trials the Nuffield Department of Primary Care Health Sciences, University of Oxford had recently undertaken, including BWEL – a trial to test the effectiveness of brief interventions for weight loss in primary care, and WRAP – an evaluation of clinical and cost effectiveness of weight loss interventions which can be delivered in primary care. We also ran a webinar on the topics.

I recently attended an Oxford CLARHC meeting where Susan updated on her work. Susan's team have conducted a series of studies to learn more about self-management of obesity. This has led to the development of a list of ten evidence-based strategies for weight loss. Developing the self-monitoring concept, they have shown that few people use self-monitoring of weight to spur specific action planning and are currently testing a newly developed intervention to support them to do so.

Susan stated her team's trial of primary care referral to a total diet replacement programme has attracted considerable attention, showing a mean weight loss of 10.7 kg at 1 year, 7.6 kg greater than usual care, with long-term modelling suggesting this would be cost effective by usual NICE standards.

Dementia diagnosis rate

It is pleasing to see that the dementia diagnosis rate in the Thames Valley SCN CCGs has now reached 67.38%. This is a great achievement and you can read more about it below.

Winter warmth

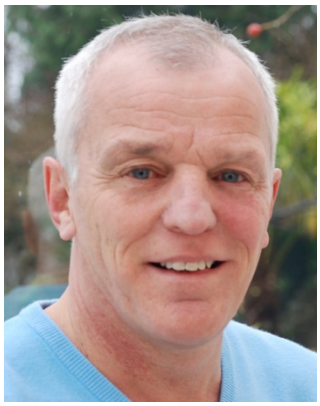
I recently read the Southampton CCG newsletter. It was good to see that the newsletter started with a section highlighting the importance of staying warm in the winter. I can't overemphasise just how important this is and hope that all local health and care systems are ensuring that patients and the public understand that message.

Flu vaccination

It's really important that all eligible people get their flu vaccination. As we all know, this helps to keep people well and helps us cope with the surge in demand for health services which happens during the winter. I recently took my father to our local pharmacist, where we both got our flu jabs. I do hope you've had your flu vaccination and ensured that your loved ones have had theirs too.

Leadership

I never cease to be amazed and humbled by the enormous amount of clinical leadership talent we have in Hampshire Thames Valley. We continue to run our 2030 leadership development programme which is building our leadership community for the decade ahead. The closing session will be in January, and feedback has been so positive that we are exploring how we may be able to run a further cohort. I have been impressed with how effectively the group collaborates, and the activity and sharing of information on the WhatsApp group is phenomenal. My thanks to the 85 participants who engaged so enthusiastically with the programme.



Professor Keith Willett and Professor Martin Vernon, two of our National Clinical Directors, were kind enough to come to Reading and speak to the Hampshire Thames Valley Leadership Forum in December as well as the leadership team from the Hampshire Isle of Wight STP.

Martin Vernon, National Clinical Director for Older People, NHS England, highlighted the importance of knowing that ageing is not uniform, and that by taking a population based segmentation approach using frailty and multimorbidity, it is now becoming possible to promote active and productive ageing for fit older people while also responding proactively to the needs of those whose resilience is declining. He also emphasized the importance of primary care, community services, social care and voluntary sectors in working closely together to support older people to live well in their communities throughout later life.

Professor Keith Willett, NHS England's Medical Director for Acute Care spoke about winter attendance prevention & profiling. Keith highlighted the doubling of respiratory attendances during the winter months, the drop in trauma admissions during the winter months, and our ability to predict likely winter attendances for heart attacks, strokes and respiratory illnesses based on the weather, and challenged us about how we deliver our services given this information.
Richard Samuel and Tim Cotton told us that health partners in Hampshire and the Isle of Wight have been working together to develop a collaborative bank which, when in full operation, would be the largest in the country. It is anticipated contracts will be signed before Christmas with commencement in the new year.

Digital

Colleagues who have attended our past Medical Directorate conferences will know the importance that we place on the digital agenda. In January we will, with Dr Mark Kelsey, be running a session for CCG chairs, medical directors and chief clinical information officers to explore the future of medical leadership driving forward the digital agenda.

The NHS England/NHS Improvement National Leadership Forum

I attended this forum on December 18th and explored amongst other things, the way we will work together jointly in the future. The session was facilitated by Helen Bevan, Sasha Karakusevic and Kathryn Perera (the latter two facilitated the launch of own NHS@2030 programme).

One of our most important pieces of work at the moment is looking at how we work at the 2 to 5 million population level to improve clinical outcomes at scale.

Life expectancy rates

I read with interest a blog from PHE entitled 'Why have increases in life expectancy slowed down in England?'.

Long term plan

On 9th January the NHS Long Term Plan was launched which I would strongly encourage colleagues to read. I think we are well placed in Hampshire Thames Valley to deliver its ambitions.

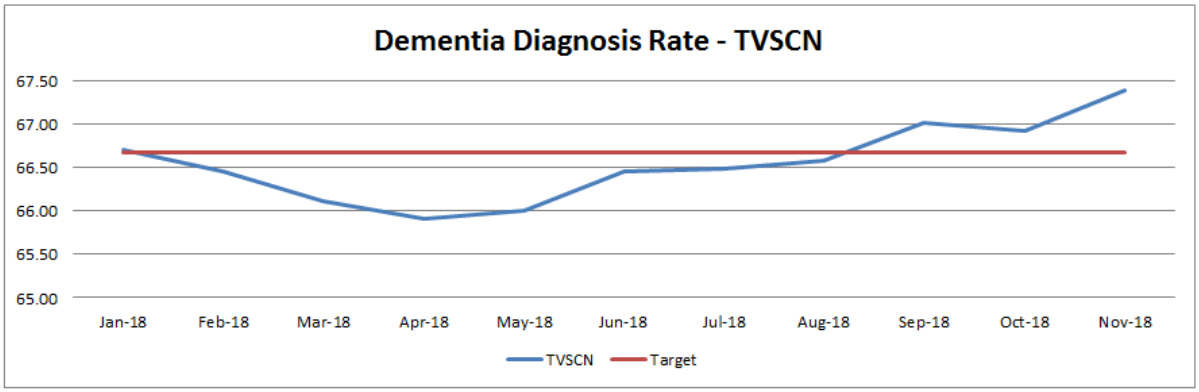
Professor Martin Gore

We would like to extend our heartfelt condolences to the family of Professor Martin Gore, the former Medical Director of the Royal Marsden. Martin made an invaluable contribution to the care of cancer patients and will be sadly missed by all. He was truly one of the nicest people one could hope to meet.

SHAHED AHMAD
MEDICAL DIRECTOR
HAMPSHIRE THAMES VALLEY, NHS ENGLAND

Dementia diagnostic rate progress

Early dementia diagnosis is essential if individuals are to access appropriate post-diagnostic support. The national ambition is for 66.7% of people with dementia to be formally diagnosed. The Thames Valley (TV) SCN region is now achieving the national target (67.38% in Nov 2018). However, variation within the region remains an issue: Dementia diagnosis rates (DDR) in TV CCGs range from 65.1% to 69.2% (November 2018 data) with significant variation in performance at GP practice level in all TV CCGs.



Dementia diagnosis rate, patients aged 65+ and CFASII denominator

	Apr-18	May-8	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
NHS Milton Keynes CCG	65.5	65.5	65.7	65.9	65.9	67.6	66.9	68.19
NHS Buckinghamshire CCG	65.0	64.8	64.7	64.7	65.0	65.1	64.8	65.14
NHS Berkshire West CCG	63.8	64.0	65.1	65.0	65.2	66.4	66.2	66.86
NHS Oxfordshire CCG	67.0	67.1	67.3	68.0	68.0	68.0	68.4	68.44
NHS East Berkshire CCG	68.3	68.6	69.9	68.4	68.4	68.6	68.4	69.20

Reducing this variation is a priority for the TVSCN, and activity during 2018/19 is focused on addressing this through four key areas:

1. **The provision of timely dementia data**: The SCN has developed a dementia dashboard providing a range of dementia metrics across the whole pathway: DDR, dementia assessment and referral in acute care, care plan review, physical health needs, antipsychotic

prescribing, mortality and place of death. The SCN also provides monthly GP practice level DDR data to assist commissioners to identify and challenge variation at a local level.

2. **Tailored clinical expertise:** The SCN provides specific dementia clinical advice and support. Over the last year, tailored support has been provided to NHS West Berkshire and NHS Buckinghamshire.
3. **Dementia leadership:** During 2017-18, the SCN provided funding and clinical leadership development to ensure that each CCG had an exemplar Dementia Friendly Practice (DFP) and additional leadership to support the delivery of their dementia programmes. Completed in April 2018, the project demonstrated significant improvements in dementia leadership skills, dementia care and DDR performance for these practices. As a result, there are now eight exemplar DFPs in Thames Valley providing additional dementia clinical leadership to champion dementia and share best practice in their CCGs.
4. **Dissemination of best practice:** Through its website and newsletter *Dementia Matters* the SCN disseminates a wide range of information and resources to support best practice in dementia. An example of a resource disseminated in 2018 was the WAM 28 coding tool, developed by a GP in Windsor and Maidenhead (WAM) CCG, to aid the identification of individuals with dementia by highlighting inappropriate coding in primary care.

For further information and advice please contact Sian Roberts, TVSCN Clinical Lead for Dementia sian.roberts2@nhs.net and Sylvie Thorn, Quality Improvement Lead for Dementia sylviethorn@nhs.net

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Appraisal team

The appraisal team has arranged and delivered appraisal meetings for all GPs eligible (and able) to meet in the last quarter and the feedback from these meetings has been very good. In the second cycle of revalidation GPs now look forward to their appraisal meetings and use them to gain support and the stimulus to work towards their full professional potential.

The GP appraisers are aware of low morale and professional isolation in general practice which impacts on GP health and the quality of patient care offered. The appraisal meeting often reveals these issues but is not a suitable time for exploring them in a mentoring model. Dr Honor Merriman, interim GP appraisal lead in Thames Valley, is exploring a GP mentorship scheme and hopes that the service can be offered soon in the Thames Valley.

A highlight in the Thames Valley service are our senior appraisers, who quality assure the process, assist revalidation recommendations and offer one to one support to each appraiser in their team. This time at the start of the second cycle of revalidation is a good time for this team to consider how they can further improve the service and we plan to meet soon to explore how best to do this.

A call for unity in hypertension management

It is known that for every 10mmHg reduction in blood pressure there is a staggering 20% reduction in the risk of cardiovascular events. Hypertension management is a critical agenda to support future-proofing the region's health and social wellbeing. In addition to stroke reduction, identifying undiagnosed patients with high blood pressure, and subsequently ensuring that their blood pressure is managed effectively, can significantly reduce the burden of angina and heart attack, heart failure, atrial fibrillation, dementia and kidney disease.

This 'prevalence and control' approach aligns with the agenda of moving care upstream and the 'prevention is better than cure' strategy.

Currently, over 40% of patients with hypertension are undiagnosed, and over 50% of patients with estimated hypertension have poorly controlled blood pressure. This presents both a huge and unnecessary risk to patients and their families on an individual level, and to the wider health and social care economies. It also presents a vast opportunity to strive for excellence by reducing the hypertension burden. As a result, the population will reap significant benefits across the system.

In 2015/16 the estimated adult population across the BOB and Frimley STPs with hypertension was 552,100. Worryingly, there were considered to be 235,400 patients with undiagnosed disease. Analysis has shown that over a three year period, if the blood pressure of those already diagnosed with hypertension was optimally treated, 570 strokes and 390 heart attacks could be averted. Furthermore, the financial savings to the system runs into millions of pounds.

Hypertension is therefore a priority area of focus for the Thames Valley Strategic Clinical Network (TVSCN), looking at significantly improving both prevalence and control in an accelerated, innovative and sustainable way.

To drive this work forward, the TVSCN has established a cardiovascular group to bring all the localities and key partners together, and is offering a suite of resources on hypertension to rapidly improve outcomes for our patients. At our second meeting on December 19 members reviewed,

discussed and gave their mandate to the proposed programme and the production of a suite of resources. These include a briefing paper and presentation pack for CCG leads to inform CCG and HWB boards, a practical guide for primary care, a CCG-focused CVD case for change, a Thames Valley ambition paper, collation of local initiatives on SCN website, and a competition for primary care in hypertension and AF achievement.

We hope to support partners who need help and focus on bringing new stakeholders into the frame. We have a challenge that cannot be underestimated but with commitment from all who live and work in the Thames Valley, there is no doubt we can do it.

For more information on the wider Thames Valley cardiovascular disease programme, contact r.thakkar@nhs.net or sangeetha.sundareshwar@nhs.net

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Visions of the Future

Visions of the Future was an event for over 150 people, designed to promote innovation, community co-production and new approaches to delivering support.

The first three speakers delivered inspiring keynotes on diverse topics:

- Dr Julie Repper, Director of ImROC, talked about co-production in practice, pulling from her significant international experience and knowledge of this area and community mobilisation.
- Menno van Doorn, Director of the Sogeti Research Institute for the Analysis of New Technology (VINT) talked about the institute's international research on digital happiness.
- Finally, Dr Karl Marlowe, Medical Director at Southern Health NHS Foundation Trust, shared the renowned approach to quality improvement of the East London NHS Foundation Trust, where he previously worked as Clinical Director.

The keynote speakers were followed by a panel discussion and presentations on local crisis innovations across Wessex. People shared local, on the ground experiences and discussed topics about changing approaches in commissioning and delivery in afternoon sessions that covered new methods using technology and data, enabling people to own their outcomes and recovery, and the emerging workforce.

The attendees were asked what further support they would like from the Wessex SCN mental health network, and the feedback will be used to shape the future work programme for the clinical network.

LeaderFest – Celebrating the Best of Leadership

On 7th November NHS Thames Valley and Wessex Leadership Academy (TVWLA) held their annual conference, LeaderFest – Celebrating the Best of Leadership, which was attended by clinical and non-clinical health and social care colleagues from across the region.

Speakers included Stephen Hart, Managing Director NHS Leadership Academy; Debbie Fleming, CEO Poole Hospital NHS Foundation Trust; and Dr Mark Spencer, GP at Fleetwood Surgery.

The themes of the festival were connection, collaboration, exploration and experimentation and how we, as health and social care colleagues, can make a difference to the wellbeing of our communities. Dr Mark Spencer connected with the festival themes by spontaneously performing 'Help!' following his inspiring workshop on how to develop meaningful relationships.

Systems leadership was discussed by many of the other national, regional and local health and social care speakers. Debbie Sorkin from the Leadership Centre led a very well received workshop on leading in complex systems. Ewan King, Director of Business Development and Delivery at the Social Care Institute for Excellence (SCIE), shared some early findings from our recently published research into leadership in Integrated Care Systems (https://www.scie.org.uk/integrated-care/leadership/systems), which TVWLA commissioned on behalf of the National Leadership Academy. Other sessions focused on talent management and inclusion.

Feedback on the event has been very positive, with one patient leader saying "I feel so privileged to have been part of the day, and so in awe of such dedicated people."

Further information about LeaderFest can be found on our website and here including photos, videos and presentations. We will be continuing to update this over the coming weeks.

Please contact avril.bryant@hee.nhs.uk for more information.

Thames Valley Cancer Alliance conference update

The Thames Valley Cancer Alliance hosted its annual conference on the 4th October 2018. This year's theme was excellence in cancer care, which the Cancer Alliance continually strives to achieve. The day brought together some 100 delegates made up of patients, charities, primary care and secondary clinicians, and clinical commissioning managers to think about what excellence in cancer care means, and hear about all the programmes the Cancer Alliance is leading to drive improvements in cancer care across Thames Valley. It also provided a valuable networking opportunity and set the stage for further cooperation among stakeholders involved in cancer care.

The conference began with opening remarks by Louise Patten, CEO Oxfordshire & Buckinghamshire CCG and Deputy Cancer Alliance Lead highlighting the values, ambitions and priorities of the Cancer Alliance and current performance against the national cancer standards.

The morning continued with three presentations offering three different perspectives of excellence in cancer care; that of the patient by Kris Hallenga, cancer research by Professor Mark Middleton and national policy by David Fitzgerald.

Delegates also heard about the Thames Valley Cancer Alliance's transformation programme and progress made against national and local priorities from each of the project leads.

You can find more information about the conference and the Cancer Alliance at: https://tvscn.nhs.uk/networks/cancer/

Cancer Alliance 62 day cancer performance

With increasing demand on cancer services and exceptional pressures across the whole of the NHS, the Thames Valley Cancer Alliance continues to work in collaboration with partners to improve 62 day performance and achieve better patient cancer outcomes.

Trusts across Thames Valley have seen a continued increase in the number of 2 week wait suspected cancer referrals across all cancer types. The 62 day cancer standard performance in September was 83%, with only 50% of trusts meeting the 85% operational standard. The significant rise in suspected urological cancers in March can be linked to the high press attention following the February announcement by Stephen Fry about his prostate cancer diagnosis. However, there has been no observed change in the conversion rate suggesting this is an appropriate rise in referrals.

Delays in any area of care have an impact on patients. But in cancer care, the amount of time a patient waits for diagnosis and treatment can affect outcomes and experience.

To read the full article and the actions being undertaken across Thames Valley to address key challenges please click the link: http://tvscn.nhs.uk/wp-content/uploads/2018/12/TVCA-Autumn-2018-Newsletter.pdf

National 62 day meeting led by Kathy MacLean

Key updates from the recent national 62 day improvement and performance meeting include:

- Clear expectation of Alliances to lead improvement and performance discussions with providers.
- All trusts in receipt of additional funding to support improvements in the prostate cancer pathway will be required to provide a range of data to assess the impact of investment. Monitoring support secured from the northern CSU in conjunction with the regional team.
- Series of national visits planned - initial learnings identified include:
    - Robust Alliance Board discussions on cancer performance including consideration of patients waiting longer than 62 days.
    - Ten high impact actions to be tested and confirmed to be in place.
- Review of PTL backlog for all providers required to determine where additional demand and capacity work may be required to support service sustainability.

National Diabetes Audit

The National Diabetes Audit (NDA) measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. The 2017-18 NDA short report was published on 8th November 2018 detailing the top level findings from audit data collected between Jan 2017 and March 2018. A full report will be published in March 2019, which will contain full key findings, recommendations and results of initial analyses into cardiovascular risk reduction and the use of statins.

Participation rates were 100% for four out of the six Thames Valley site which demonstrated strong performance and all sites have worked hard to deliver their Diabetes Transformation Bid projects.

Significant increases in the achievement of the 8 Care Processes (8CP) have been seen in all sites. Type 1 diabetes 8CP varied from 39.2% in Bucks to 57.1% in Surrey Heath. Type 2 diabetes 8CP varied from 61.3% in North East Hampshire & Farnham to 76.5% in Surrey Heath.

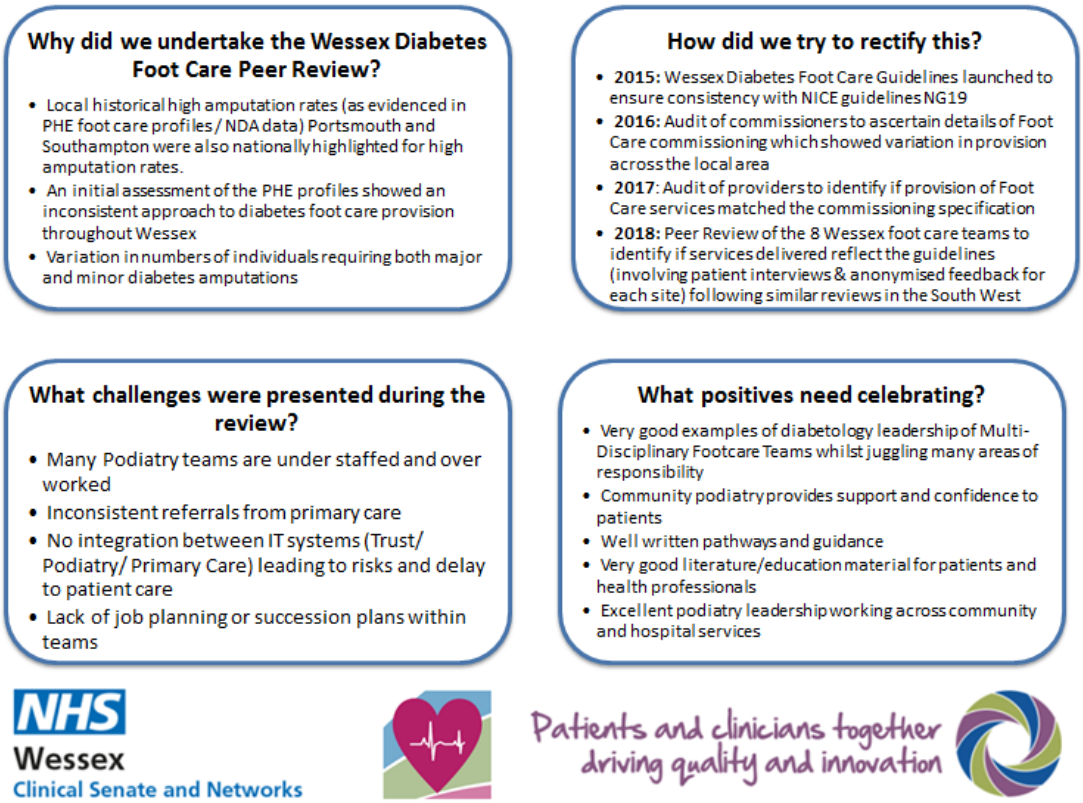
The Thames Valley 2020 ambition is for at least 40% of all patients with diabetes to achieve the 3 Treatment Targets (3TT) on a regular basis. Attainment of the 3TT showed little change from 2016-17 NDA data. Type 1 diabetes 3TT varied from 13.8% in Surrey Heath to 23.2% in Berks West. Type 2 diabetes 3TT varied from 39.2% in Oxon and Berks West to 46.8% in North East Hampshire & Farnham. It is anticipated however that the improvements seen in the 8CPs will be reflected next year in improvement in achievement of the three treatment targets.

Congratulations to Frimley STP who have achieved 2nd to top ranking nationally for all STPs in the 3TT for patients with type 2 diabetes in 2017/18.

Wessex diabetes footcare

The Wessex cardiovascular network diabetes forum has recently undertaken a peer review of the diabetic footcare services across the area, primarily focusing on amputations. We were extremely lucky to have Richard Paisey, Honorary Consultant in Diabetes, South West CVD Diabetes Footcare Lead to lead on the review, along with Mike Townson, Podiatrist acting as Project Lead. Richard undertook a similar review in the South West in 2017. Each review was attended by the project manager and patient participation lead and other stakeholders from the Wessex Clinical Network. 100 people have been involved with the reviews, as well as 16 patients who were interviewed prior to the site visits.

There will be a full discussion around the findings of the report at the Wessex diabetes stakeholder event on 9th May 2019. For more information: england.wessexscn@nhs.net.



Community nurse administration of insulin: collaborative working between Health Education England and Wessex cardiovascular clinical network

Health Education England (HEE) estimated that approximately 10% of community nursing time was spent administering insulin to patients. Wessex cardiovascular disease clinical network (CVD CN) were contacted by HEE, who wanted to find a solution and ascertain if this would be within the scope of the Wessex diabetes forum. The answer was yes.

Solution – first steps

The CVD CN arranged a meeting between community nursing teams' representatives, a diabetes specialist nurse and HEE. Each patient requiring the community nursing team to administer their insulin amounted to one hour of nursing time per day (2 x 30 mins) per patient. For an average sized CCG, this worked out at two WTEs per week (approx. £70,000 pa). Some of these patients were receiving very low doses of insulin, e.g. two units twice a day.

To inform the working group of the true scale of the challenge, an audit with one pilot CCG was undertaken. The pilot CCG agreed to ask all of its community nursing team to record, on one day:

- Number of patients they attend to administer insulin
- Insulin dose
- If the patient has T1 or T2 diabetes
- If the patient requires any other nursing intervention

- If the patient has any other co-morbidities
- If the patient lives alone
- If the patient lives in a care home
- Length of visit.

Solution – next steps

Our aim is to improve the patient experience by developing a cost effective, clinically developed and clinically owned pathway, which will ensure a consistent approach to care for this group of patients, without them having to be reliant on waiting for community nursing team visits to administer their insulin.

DadPad neonatal

Being a new dad can be a difficult thing to come to terms with, and being the parent of a child in neonatal care potentially brings even more complex emotions and problems, as well as a wealth of complex information to digest. The idea for DadPad Neonatal was conceived by consultant neonatologist Professor Minesh Khashu, who recognised that there was a need for better communication and support for fathers of babies on neonatal units.

A pack of laminated cards contains practical information and advice on relevant matters. These include: how dads can best help themselves and their partners as they each deal with their feelings and emotions; where to go to seek further help, support and information; and practical guidance on holding, handling, bonding with and caring for their premature baby.

The resource should become a valuable tool for fathers during this sensitive time, as well as growing into a 'keepsake' book for the father, child and family, with spaces in which to record information and emotions.

It is hoped that the DadPad Neonatal will significantly improve a dad's understanding of their baby's care and treatment. It will also help in conversations with healthcare professionals on a range of topics.

Professor Khashu hopes that other neonatal units around the country will adopt the DadPad Neonatal and benefit from the support that it offers.

https://thedadpad.co.uk/neonatal/

Wessex Cancer Alliance – Patient and public engagement

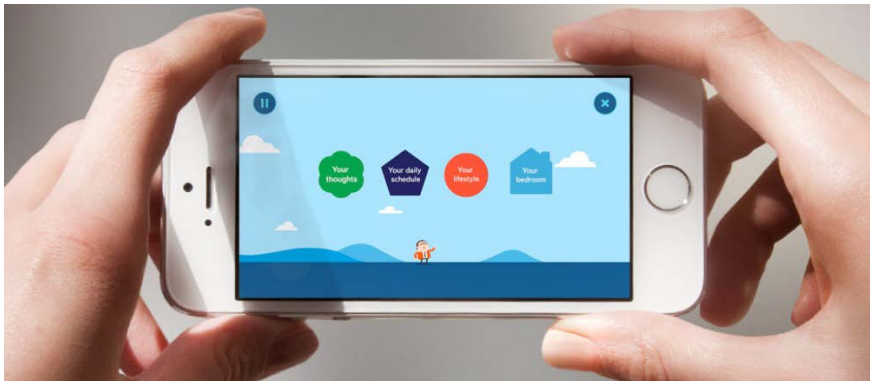
One of the three main aims within the Government's paper, Improving Outcomes: A Strategy for Cancer, is to put the patient at the heart of public services. To realise this aim, the Wessex Cancer Alliance have undertaken a number of patient and public involvement (PPI) projects over 2018. This has included three cancer information and awareness events in Southampton, Portsmouth and the Isle of Wight, which involved working in partnership with local patient support groups, charities, CCGs and other organisations. The events reached several hundred people who were offered information, signposting and a chance to give their views on local cancer services.

Other projects have included patient interviews around lung cancer screening; focus groups with women about barriers to cancer screening; and an event for professionals and patients to discuss the development of sustainable health & wellbeing events for people living with and beyond cancer. Future PPI work within the Alliance includes developing an approach to supporting patient representatives in site-specific steering groups, gathering patient feedback on bowel screening, and working with local communities to set up a social capital network to raise awareness of cancer signs and screening.

Free access to Sleepio online sleep improvement programme

Sleepio is an online sleep improvement programme; a fully automated, interactive web-based tool. Sleepio is available free to all adults living in Berkshire, Buckinghamshire, Milton Keynes and Oxfordshire from October 2018 until autumn 2019. This is the first large-scale NHS rollout of direct access digital medicine that requires no GP referral, no prescription, and no sleeping pills. Oxford AHSN is leading this initiative in partnership with Big Health, the company behind Sleepio. It is supported by NHS England and the NHS Innovation Accelerator and funded by Innovate UK. A health economic evaluation will be conducted at the end of the trial to discover the impact of promoting digital medicine at scale to the general population through GP surgeries, direct access and employers. NHS organisations promoting the initiative to their staff and patients include Buckinghamshire Healthcare, Oxford Health and Oxford University Hospitals. Sleepio provides tailored, engaging advice 24/7. Its six week self-help programme based on cognitive behavioural therapy is clinically proven to improve sleep, mental health and productivity. It has been proved to help over seven out of ten poor sleepers achieve and maintain healthy sleep patterns leading to improved quality of life.

You can find more information here: http://bit.ly/sleepAHSN or access the Sleepio NHS portal at www.sleepio.com/NHS



Better diagnosis of pre-eclampsia improves patient safety and reduces burden on maternity services

Pre-eclampsia (PE) is a multi-system hypertensive disorder which complicates up to one in every 20 pregnancies and is a major cause of maternal and fetal morbidity, impacting pregnant women and their families and placing significant economic and capacity burdens on maternity systems. Clinical teams have a high degree of suspicion for PE and a low threshold to admit pregnant women with suspected PE. However, only a small proportion of these go on to develop PE. The Oxford AHSN is supporting the roll-out and adoption of a new, more accurate test pathway. It has been taken up by two Thames Valley hospitals to date, with others developing business cases to take it forward. For each hospital the Oxford AHSN is developing insight into pathways and needs, and providing project management and business support for adoption. The test reduces initial admission for the suspicion of PE and allows an appropriate regimen of planned care to be delivered, resulting in better care for

individual women and more efficient use of NHS resources in line with the Better Births national maternity review, 2016.

More here: http://bit.ly/pre-ecl

National sepsis identification tool emerges from research work in Oxford/Wessex

The NHS has launched a tool that for the first time accurately measures the number of patients admitted to hospital who are at risk of sepsis, which is notoriously difficult to detect. All hospitals are being encouraged to use the Suspicion of Sepsis (SOS) Insight Dashboard which accurately measures how many patients are at risk of sepsis. By showing the numbers of admissions, rates of survival, and lengths of stay, it gives clinicians the clearest information yet for which types of infections can cause patients to deteriorate quickly, and which treatments are most effective at saving lives. The dashboard was created by Imperial College Health Partners (ICHP) in collaboration with NHS England and NHS Improvement. It builds on the methodology for measuring sepsis published by the Oxford Patient Safety Collaborative (PSC) last year. Matt Inada-Kim, national advisor to NHS England on sepsis, praised the work of the Oxford PSC team led by Professor Charles Vincent in starting the journey towards the creation of the national sepsis dashboard. The project was a finalist in the enhancing care through sharing data and information category of the 2018 HSJ Awards.

More here: http://atlas.ahsnnetwork.com/suspicion-of-sepsis/

Wessex mechanical thrombectomy pathway

Approximately 10% of individuals who experience a stroke could be eligible for mechanical

thrombectomy, and thereby benefit from improved treatment outcomes without experiencing disabling long-term consequences (national stroke meeting, 2017).

In March 2017, facilitated by the Wessex cardiovascular disease clinical network, the stroke forum agreed to prioritise a mechanical thrombectomy pathway covering the Wessex population (2.8 million). A working subgroup was established, consisting of clinicians (stroke, neurology, radiology, nursing), local ambulance trusts, specialised commissioning and CCG commissioners. Over the next year the subgroup (led by Dr Jo Lovett) met regularly and communicated by email to develop a clear care pathway covering:

- Pre-hospital alert
- Imaging guidance
- Communication with Wessex Neuro Centre (WNC) (agreed thrombectomy centre for Wessex)
- Ambulance transfer
- Preparation at WNC prior to patient arrival
- Patient assessment
- Thrombectomy procedure
- Post procedure care
- Repatriation of patient
- Governance (data collection, MDT meetings etc).

The pathway had to take into account the optimum time from outset of stroke to mechanical thrombectomy (four hours). This could involve a typical patient being transferred from home to their local hospital for initial assessment/treatment (including imaging and TPA infusion), and then transfer to WNC within the agreed time frame.

The Wessex stroke mechanical thrombectomy pathway was agreed and adopted for use throughout Wessex in October 2018.

This pathway is an excellent example of collaboration between clinicians and commissioners to address variation and work towards improving access to care and patient outcomes. All seven acute hospital trusts, WNC, both ambulance trusts, all CCGs and specialised commissioning worked together to develop and implement a pathway which crosses organisational boundaries.

Buckinghamshire 90% atrial fibrillation detection

Reduction in stroke burden by reducing risk factors, such as hypertension and atrial fibrillation, is a high priority across the region. Atrial fibrillation (AF), is a common condition where the heart beats irregularly, increasing the risk of blood clots in the brain. Causes are manyfold and include high blood pressure, coronary disease, mitral valve disease, heart failure, obesity, sleep apnoea, thyroid disease and infection. With an ageing population, the number of people with AF is increasing over time. Patients with this condition have a fivefold increased risk of stroke, and those who suffer an AF-related stroke have poorer outcomes in terms of independent living.

The detection of undiagnosed AF and treatment with warfarin or other anticoagulants is part of the prevalence and control strategy in Buckinghamshire. A multi-pronged approach in Buckinghamshire including education, opportunistic screening, data feedback, quality improvement projects with the AHSN and a shift in culture have vastly increased the detection and control of AF to 90% and 87% respectively. The stroke rate has significantly fallen, demonstrating real clinical outcomes which have been recognised by the Atrial Fibrillation Association, Public Health England and the Stroke Association.

We are keen at the Thames Valley Strategic Clinical Network to promote and accelerate the detection and control of AF and hypertension, with the aim of reducing cardiovascular disease in the region.

For more info on the Buckinghamshire story or for any information on the wider Thames Valley CVD programme, contact r.thakkar@nhs.net or Sangeetha.sundareshwar@nhs.net

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Wessex mental health and dementia network

The Wessex mental health and dementia network publishes a monthly newsletter that summarises and celebrates the highlights from the previous month, whilst also seeking to establish where the key issues are in the Wessex region in so far as the provision of mental healthcare is concerned. Through The View we set the scene for the focus of each newsletter.

Following on from two very successful events that were hosted by the network, this months' edition focused on innovation, with emphasis on co-production, technology (digital happiness) and the importance of the workforce.

One of the network's key areas of focus is to energise and support change across clinical and social care boundaries. Change is often difficult and there can be many roadblocks and barriers along the way. In this month's edition of the newsletter, we showcase examples of work going on in Wessex and beyond to support transformation of mental health and dementia services.

Embedded within the newsletter is a horizon scanning section which is concerned with establishing what is currently going on locally, nationally and internationally, providing intelligent comment as well as identifying where any gaps are. That way, network and local commissioners and providers stay up to date with any new developments and updates, as well as initiatives in both adult and young people's mental health services.

For more information on the MHDN, please click on the following link:
https://wessexsenate.nhs.uk/clinical-networks/mhdn

You can subscribe to the Wessex MHDN newsletter here.

Children and young people's mental health

Eating disorder best practice forum

The Thames Valley children and young people's (CYP) mental health network has facilitated an eating disorders best practice forum for over two years, which brings together clinicians from the CYP eating disorders community to translate and embed national eating disorders standards, and best practice guidance into local practice. At the most recent forum, it was agreed that there is an opportunity to improve the way that access and outcomes in the services are recorded and measured to support improvements in the way that they are delivered.

On 15 November the CYP network brought together local stakeholders in the Buckinghamshire, Oxfordshire and Berkshire West STP to take this forward. Anne O'Herlihy (Children and Young People's Mental Health Project Manager, Clinical Policy and Mental Health Strategy, NHS England), set the national strategic direction for community eating disorders services. Els Drewek (Intensive Support Manager for NHS Improvement) provided clarity on the national reporting requirements.

Following stimulating discussions, there was a strong consensus in the room to collaborate and deliver the following:

- Aligned reported outcome measures across the region.
- Agree a local process for recording of patients who have not had an evidence-based treatment.
- Deliver improvements that support the early identification of eating disorders.

These improvements will be taken forward through the future eating disorders best practice forum on 12 February 2018.

Delivering mental health support teams in schools

The CYP network will be supporting the delivery of mental health support teams in schools across Buckinghamshire, Oxfordshire and Berkshire West, which were successful in their bid for funding this innovative pilot. The support teams will work between schools and child and adolescent mental health services (CAMHS), and offer support and treatment in schools and will be fully operational by December 2019.

Winter planning for mental health

The Thames Valley SCN, alongside NHSE and NHSI colleagues, brought system partners from across the patch to participate in a winter planning scenario workshop for mental health.

This was co-produced alongside our provider STP and ICS colleagues to encourage networking, build understanding and share learning from our systems to discuss 'real life' scenarios and the pressures being experienced across our mental health partners, ambulance service, acute trusts, local authorities and police with resulting actions being considered that each organisation felt should and would be taken in each case.

The feedback received to date has been positive, and we are pleased to hear that further sessions have been requested. A report from this event will be available in the new year – please email James Carter for more detail – james.carter1@nhs.net

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National CVD prevention system leadership forum

At the end of November, Rebecca Goldberg, Senior Support Manager at Public Health England, attended the fifth meeting of the National Cardiovascular Disease Prevention System Leadership Forum (CVDSLF). The meeting brings together partners from over 35 organisations, including government, NHS England, other arm's length bodies, the third sector, royal colleges, clinicians and academia.

As a group, we have been collectively working to establish CVD ambitions for England to improve the detection and optimal management of blood pressure, atrial fibrillation (AF) and high cholesterol. Originally positioned as five year ambitions, we have now agreed to extend the time period to ten years to align with the NHS Long Term Plan.

The ambitions and these risk factors will be discussed in more detail at the annual CVD Prevention Conference on 14 February 2019. Don't miss out, register today!

Physical health and SMI

People living with severe mental illness (SMI) face one of the greatest health inequality gaps in the UK. In the Thames Valley, life expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness.

Around 12,000 fewer people would die per year from cardiovascular disease (CVD) if people with SMI had the same outcomes as the general population. A combination of factors including the side effects of antipsychotic medication, lifestyle, diagnostic overshadowing and difficulties accessing mainstream health services can all contribute to the reduced life expectancy.

The Five Year Forward View recognises the need to address this and includes the following commitment for people with severe mental illness (schizophrenia, bipolar and psychotic disorders):

By 2020/21, 280,000 people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.

CCGs should offer NICE-recommended screening and access to physical care interventions to cover 30% of the population with SMI on the GP register in 2017/18, moving to 60% population from the following year. The checks are to be delivered across primary and secondary care.

In order to support progress with this commitment the mental health network held a Thames Valley wide workshop on 5 December 2018 in Reading, and you can see the presentations here.

At this workshop, national and local leaders highlighted the case for change and progress towards the above Five Year Forward View goals. CCGs and Trusts have set up models for completing the health checks and whilst further embedding is needed, there now needs to be a focus on ensuring the interventions are in place to improve physical health and support is available to enable those with mental illness to access these.

A whole system approach is needed to do this and at the workshop attendees from primary care, secondary care, local authority and voluntary sector heard evidence of the importance of physical activity for this group and heard about local initiatives where peer support and physical activity were having a positive impact on improving health. The workshop also included a system-wide discussion on what else can be done to help address this inequality.

Newsletters

Thames Valley SCN End of Life bulletin
Thames Valley SCN Dementia Matters
Thames Valley Cancer Alliance
Oxford AHSN newsletter
Thames Valley and Wessex Leadership Academy newsletter